Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

INDIVIDUAL SERVICE AGREEMENT

Do not use for CAP Waiver Services

CLIENT'S NAME	DDD NUMBER
CRITICAL MEDICAL ALERT	
STRENGTHS (INCLUDING SUPPORT SYSTEMS, AREAS OF INDEPENDENCE/COMPETENCIES)	
SUPPORTS NEEDED/REQUESTED	
PROPOSED SERVICES	
MONITORING PLAN (INCLUDING WHO MONITORS, HOW OFTEN, HOW REPORTED)	
CLIENT'S SIGNATURE	DATE
PARENT/GUARDIAN'S SIGNATURE	DATE
OTHER PARTICIPANTS	
CASE MANAGER'S SIGNATURE	DATE

ADMINISTRATIVE HEARING REQUEST

The client and the client's representative have the right to appeal the DDD field services' decision noted on the reverse side of this form. **THIS FORM MUST BE COMPLETED AND RETURNED WITHIN 28 DAYS OF RECEIPT OF THE CLIENT GETTING THE INDIVIDUAL SERVICE AGREEMENT TO APPEAL THIS DECISION.**

The client or the representative may request a hearing by completing this following request and mailing it to:

OFFICE OF ADMINISTRATIVE HEARINGS
PO BOX 42489
OLYMPIA WA 98504-2489

I, _____, (check one of the following boxes)

- ☐ the person for whom services are requested,
- ☐ the parent/guardian for _____, who is under 18 years of age,
- ☐ the representative for _____,

request an administrative hearing to review the decision of the Department of Social and Health Services (DSHS), Division of Developmental Disabilities (DDD) Field Services as set forth in the Individual Service Agreement.

Please complete the following:

CLIENT'S NAME	TELEPHONE NUMBER ( )	DDD NUMBER
STREET ADDRESS	CITY / STATE / ZIP CODE	
CLIENT'S SIGNATURE		DATE

If the client is or will be represented at the hearing, please complete the following:

REPRESENTATIVE'S NAME	TELEPHONE NUMBER ( )
NAME OF ORGANIZATION	
STREET ADDRESS / CITY / STATE / ZIP CODE	

The above representative is:

- ☐ parent.
- ☐ guardian.
- ☐ attorney.
- ☐ other (specify): _____.